

Report of Termination of Disability and/or Payment

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs



Part - A General

1. Name of Injured Employee (last, first, middle)		2. Social Security Number	3. OWCP File Number (If known)	
4. Department or Agency		5. Bureau or Office		
6. Name and Address of Reporting Office (Include Zip Code)				
7. Date and Hour of Injury (Mo., day, year) <input type="checkbox"/> AM <input type="checkbox"/> PM		8. Date and Hour Stopped Work (Mo., day, year) <input type="checkbox"/> AM <input type="checkbox"/> PM		9. Date and Hour Pay Stopped (Mo., day, year) <input type="checkbox"/> AM <input type="checkbox"/> PM
10. Date and Hour Returned to Work (Mo., day, year) <input type="checkbox"/> AM <input type="checkbox"/> PM				
11. Employee's Work Week On Return To Duty If Other Than Monday Through Friday S M T W T F S		12. Present Pay Rate If Different From That Received At Time Employee Stopped Work. a. Base Pay b. Subsistence c. Quarters d. Other (Specify)		
13. Inclusive Dates Employee Received Pay For Any Part of The Period of Absence Because of:				
a. Annual Leave		b. Sick Leave		c. Other (Specify)
From: Through:		From: Through:		From: Through:
14. Has Employee's Work Assignment Been Changed Because of Disability Resulting From This Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Describe The Type of Work Employee Is Performing.				
15. If Interrupted, Show Dates Deductions For Health Benefits and/or Optional Insurance Were Resumed (Mo., day, year) <u>Health Benefit</u> <u>Optional Insurance</u>		16. If Health Benefits Option Has Changed Since Disability Began, Show New Code Number and Date of Change (Mo., day, year) Number _____ Date _____		
17. Remarks				

Part - B Continuation of Pay

18. Inclusive Dates That The Employee's Regular Pay Continued During The Period Of Disability. Do not include period of sick or annual leave (Mo., day, year) From: Through:		19. Show The Gross Dollar Amount Of Regular Pay Which The Employee Received During The Period Of Disability. Do not include pay received for sick leave or annual leave. \$		
20. If Pay Rate Changed During The Period Employee Was Receiving Continuation Of Pay, Show The Date of Change (Mo., day, year)		21. If Pay Rate Changed During The Period Employee Was Receiving Continuation of Pay, Give New Rate a. Base Pay b. Susistence c. Quarters d. Other (Specify)		
22. Signature of Supervisor		23. Title and Office Phone Number		24. Date (Mo., day, year)